
# Position Request / Candidate Review

# Impact Summary Form

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| **Please retain a copy of this form when you submit for a position request so that it can be used when submitting the candidate information.** |
| **PART A****POSITION REQUEST INFORMATION***(Complete PART A when submitting a request for a position)* | **PART B****CANDIDATE REVIEW INFORMATION***(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)*  |

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| **DEMOGRAPHIC INFORMATION** |
| **EXISTING POSITION NUMBER:**  |
| **Anticipated Start Date** |  | **Anticipated Start Date** |  |
| **Department** |  | **Department** |  |
| **Division** |  | **Division** |  |
| **Program (if applicable)** |  | **Program (if applicable)** |  |
| **Primary Hospital** |  | **Primary Hospital** |  |
| **Primary Site** |  | **Primary Site** |  |
| **Name of Physician Leaving (if applicable)** |  | **Candidate Name** |  |
| **Departure Date of Physician Leaving****(if applicable)** |  | **Candidate Leadership Title****(If applicable ie. Chair/Chief)** |  |
| **Full or Partial FTE****(1.0 / 0.75 / 0.50)** |  | **Full or Partial FTE****(1.0 / 0.75 / 0.50)** |  |
| **PART A****POSITION REQUEST INFORMATION**(Complete PART A when submitting a request for a position) | **PART B****CANDIDATE REVIEW INFORMATION****(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)** |
| **RATIONALE FOR SUPPORT** |
| Please provide an **IN-DEPTH** statement including clinical, academic & research information in support of this request. Outline how this position request is required to meet an ongoing quality improvement initiative. **If the position is “Mission Critical” please provide a brief statement to support.** | Please reaffirm the original rationale that was submitted with the initial position request in PART A to ensure it is updated for the candidate review process.  |
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| **PROXY INFORMATION** |
| Please provide the name of a physician whose practice is similar in terms of patient volumes, resource usage, etc. If this is a replacement position, the appropriate proxy may or may not be the departing physician. If there is a difference in resource impact, please specify in greater detail under the Rationale field. |
| **Proxy Name:** | **Proxy Name:** |
| **Does the position workload expect to mirror this proxy’s workload? Yes No** If no, please explain: | **Does the position workload expect to mirror this proxy’s workload? Yes No** If no, please explain. If the candidate is requesting new special equipment, technology, or equipment that will result in incremental costs in your own or another department, please explain. |
| **CLINICAL RESOURCE INFORMATION** Please indicate below the room number or N/A if not applicable |
| **Physician Office Room Number** |  | **Physician Office Room Number** |  |
| **Existing Secretary Name** |  | **Proposed Secretary** | **Existing** **New Hire** |
| **Secretary Office Room Number**  |  | **Secretary Office Room Number**  |  |
| **OR Hours / Week** |  | **OR Hours / Week** |  |
| **Avg Number of Inpatient (Beds)** |  | **Avg Number of Inpatient (Beds)** |  |
| **Outpatient Clinic:** |  | **Outpatient Clinic:** |  |
| **Clinic Hours / Week** |  | **Clinic Hours / Week** |  |
| **PART A****POSITION REQUEST INFORMATION**(Complete PART A when submitting a request for a position) | **PART B****CANDIDATE REVIEW INFORMATION****(Complete PART B once a candidate has been identified. It is not necessary to complete areas within PART B that do not differ from PART A)** |
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| **Site** | **MON** | **TUES** | **WED** | **THURS** | **FRI** |
| **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** |
| **UH** |  |  |  |  |  |  |  |  |  |  |
| **VH** |  |  |  |  |  |  |  |  |  |  |
| **SJH** |  |  |  |  |  |  |  |  |  |  |

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| **Site** | **MON** | **TUES** | **WED** | **THURS** | **FRI** |
| **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** | **AM** | **PM** |
| **UH** |  |  |  |  |  |  |  |  |  |  |
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| **REQUEST FOR A NEW POSITION – PRIORITIZATION CRITERIA** **(if applicable and known)** |
| **Position Number for a NEW position will be assigned by Medical Affairs:****Please use the rationale section that follows to outline the evidence to support the following 4 criteria to prioritize the review of the NEW position. Check off each criteria that applies (if applicable):**1. **Identified by the Department leader as “Mission Critical” which are positions that severely impact a service’s ability to sustain current level of service (clinical or academic) if not recruited , or addresses a pressing unmet clinical or academic need;**
2. **Addresses institutional priorities of Access, Infection Control or Research Capacity;**

1. **Has identified resources in place to support the new position (Office, Clinic, OR, Diagnostics – Imaging & Labs, Health Disciplines, Research and University commitments);**
2. **The known impact on diagnostic services can be accommodated as follows:**

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| **MODALITY** | **VOLUME** | **COMMENTS** |
| **<50** | **50-100** | **>100** | **N/A** |
| **X-ray/Fluoroscopy** |  |  |  |  |  |
| **Ultrasound** |  |  |  |  |  |
| **CT** |  |  |  |  |  |
| **MRI** |  |  |  |  |  |
| **Angio-Interventional** |  |  |  |  |  |
| **Mammography** |  |  |  |  |  |
| **Radioisotope (Nuclear Medicine)** |  |  |  |  |  |
| **Other (please explain)** |  |  |  |  |  |

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| **The impact on the following health disciplines is identified as follows:**

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| **Health Discipline:** | **Impact:** |  |
|  | **Yes** | **No** | **Additional Services Required:**  |  |
| **Audiology** |  |  |  |  |
| **Clinical Dietitians** |  |  |  |  |
| **Occupational Therapy** |  |  |  |  |
| **Physiotherapy** |  |  |  |  |
| **Psychology** |  |  |  |  |
| **Social Work** |  |  |  |  |
| **Speech Language Pathology** |  |  |  |  |
| **Other (Please explain)** |  |  |  |  |

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| **The impact on pharmacy services is identified as follows:** |
| **The impact on laboratory services is identified as follows:** |
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| **RESEARCH RESOURCE INFORMATION**Please indicate below the room number or N/A if not applicable. If research is a part of the candidate’s practice profile, please complete the Research Impact Confirmation Form available from Medical Affairs |
| **Dry Lab** |  | **Dry Lab** |  |
| **Wet Lab** |  | **Wet Lab** |  |
| **Clinical Trials** |  | **Clinical Trials** |  |
| **Clinical Research Space** |  | **Clinical Research Space** |  |
| **Other: i.e. Nurse Practitioner / Fellow Office / Research Asst.** |  | **Other: i.e. Nurse Practitioner / Fellow Office / Research Asst.** |  |
| **Are you able to meet all of the research space requirements of this position within your program’s existing research space?**  |  | **Are you able to meet all of the research space requirements of this position within your program’s existing research space?**  |  |

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| **CAPITAL COSTS (EQUIPMENT, ETC)**Please provide a description of the capital funding required |
| **If the position is a replacement, are Incremental costs anticipated? Please explain below:****If the position is a new position, will the workload be redistributed or are incremental costs anticipated? Please explain below:** | **Describe the capital funding required to support the candidate and indicate Amount ($) anticipated.** |
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| **ACADEMIC ROLE CATEGORY POSITION PROFILE** Please indicate the percentage of time allocated for each category (must add up to 100%): |
| **Clinician Teacher** **Clinician Researcher** **Clinician Educator** **Clinician Scientist** **Clinician Administrator**  | **Clinician Teacher**  **Clinician Researcher** **Clinician Educator** **Clinician Scientist** **Clinician Administrator** If the category selected is a Clinician Researcher, Educator or Scientist, does the candidate meet the specific requirements of that category: Yes No  |
| **Clinical Service** |  | **Clinical Service** |  |
| **Teaching** |  | **Teaching** |  |
| **Research** |  | **Research** |  |
| **Administration** |  | **Administration** |  |
| **Health Care Leadership/Role Model/General Contributions** |  | **Health Care Leadership/Role Model/General Contributions** |  |

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| AFP INFORMATION Please indicate Yes, No, or N/A – Not applicable |
| Is the position replacing a physician who was/is a Phase 3 participant?  | Will the candidate be eligible for Phase 3 AFP funding? |

**DECLARATION**

* The department has consulted with the appropriate university, hospital and research representatives and verified that the above-mentioned resource information is correct and that the position profile accurately reflects the planned activities

of the position requested.

* There is no apparent or potential conflict of interest with this candidate and any misrepresentation of information on this form may be grounds for denial of appointment.
* The interview of this candidate included multiple individuals involved in the review and decision process and retention of analysis documentation is available for review.

POSITION REVIEW - PART A

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Department Chair / Chief

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Date

 CANDIDATE REVIEW - PART B

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Department Chair / Chief

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Date

Please send this form to Gloria Castelo at Medical Affairs

Phone: 519-685-8500 (ext. 75127) / Fax: 667-6844 (76844) / Email: Gloria.castelo@lhsc.on.ca